PRINTED: 11/10/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3.000	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	22 SA RECORD 2574 (1980)		A. BUILD	DING 01 - MAIN BUILDING 01		.,	
		445302	B. WING)	11/0	8/2010	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ELIZABETHTON			S	STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E ELIZABETHTON, TN 37643			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(XS) COMPLETION DATE	
K 017 SS=D	Corridors are separ constructed with at rating. In sprinklered to resist the non-sprinklered but above the ceiling, at the underside of permitted by Code, waiting areas, dining may be open to the conditions specified be separated from walls if the gift shop 19.3.6.1, 19.3.6.2.1 This STANDARD is Based on observation corridor walls were constructed with a Irrating. The findings include Observation on Novervealed wall penet station janitors closs NFPA 101 LIFE SAD Doors protecting correquired enclosures.	s not met as evidenced by: on the facility failed to assure separated by walls east 1/2 hour fire resistance	K 01	What corrective action(s) will be accomplished for those residents have been affected by the deficiency of the series of the ser	is found to int practice? practice. intenance	12/25/10	
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XXQJ21

Facility ID: TN1004

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445302			A, BUILD	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		B. WING		11/0	B/2010	
	ROVIDER OR SUPPLIER RE CENTER OF ELIZ	ABETHTON	S	TREET ADDRESS, CITY, STATE, ZIP CO 1641 HIGHWAY 19E ELIZABETHTON, TN 37643	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETIO DATE
K 018	Continued From page 1 those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.		K 01	K 018 NFPA 101 Life Safety Standard SS=D What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were effected by this practice. The maintenance supervisor made rounds and all damaged fire doors have been ordered and will be replaced. Residents identified as having the potential to be affected by the same deficient practice. What corrective actions will be taken? All residents have a potential to be affected. Education was given to maintenance staff on 11-24-10 the importance of ensuring that firerated doors are not damaged. What measures will be put into placed or systematic changes will be made to ensure that the deficient practice does not recur?		12/25/10
	Based on observations of doors protecting of doors constructed wood. The findings included the findings included the south the central bath on the north nurses streeplaced. NFPA 101 LIFE SAR Door openings in street.	is not met as evidenced by: ion the facility failed to assure pridor openings are substantial of 1 3/4 inch solid bonded core ed: ed: vember 8, 2010 at 11:00 a.m. central bath on the 300 hall, the 300 hall, the clean utility at ation and the kitchen/dining everely damaged and must be AFETY CODE STANDARD moke barriers have at least a ection rating or are at least	K 02	Weekly rounds will be conduct maintenance supervisor or desithat fire-rated doors are not dated as the corrective action of the corrective action of the corrective action of the corrective action of the corrective director ensure compared to the consumer of the corrective director ensure compared to the PI meeting by the consumer of the correction of t	ignee to ensure maged. will be clent practice ed by the pliance with Life anding will be ED monthly for sts of: M.D., SDC, Social ctivities, HR., Dietary, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
	2	445302	B. WIN	G_		11/08	3/2010	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF ELIZABETHTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E ELIZABETHTON, TN 37643					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 027	protective plates the from the bottom of Horizontal sliding of Doors are self-closs accordance with 1s not required to swill latching is not required to swill latching. The findings included the findings included with 20 million later late	bonded wood core. Non-rated at do not exceed 48 inches the door are permitted. loors comply with 7.2.1.14. ing or automatic closing in 3.2.2.2.6. Swinging doors are not with egress and positive ired. 19.3.7.5, 19.3.7.6, is not met as evidenced by: lion the facility failed to assure provided with a 20 minute fire led: evember 8, 2010 at 1:00 p.m. a doors in the facility were not linute fire protection rating large and provided with 3/4 hour an approved automatic fire em in accordance with 8.4.1 beets hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or citive plates that do not exceed bottom of the door are			K 027 NFPA 101 Life Safety Stand SS=D What corrective action(s) will be accomplished for those residents in have been affected by the deficien. No residents were effected by this p. Doors were ordered and will have the protection rating labels. Residents identified as having the to be affected by the same deficien. What corrective actions will be ta All residents have a potential to be a Education was given to maintenance 11-24-10 on the importance of ensuall smoke doors have fire protecting and their labels. What measures will be put into playstematic changes will be made to that the deficient practice does not weekly rounds will be conducted by maintenance supervisor or designed all smoke doors have fire protecting and their labels. How the corrective action(s) will immonitored to ensure the deficient will not recur? Weekly rounds will be reviewed by executive director ensure compliants Safety Code. Weekly round finding taken to the PI meeting by the ED rethe next 3 months which consists of D.O.N., ADON Rehabilitation, SDC Service, Executive Director, Activing Admissions, Medical Records, Dictional Housekeeping Beginning Dec. 7 20	ound to t practice? ractice. he fire potential ht practice. ken? hffected. he staff on ring that he ratings acced or o ensure for trecur? y to ensure he ratings be practice the ce with Life g will be nonthly for f. M.D., C. Social ties, HR, tary, and	12/25/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445302	A. BUILD		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		ABETHTON	-	1	REET ADDRESS, CITY, STATE, ZIP CODE 641 HIGHWAY 19E LIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 067 SS=D	RE CENTER OF ELIZABETHTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure all hazardous areas are provided with 3/4 hour fire rated doors and construction. The findings included: Observation on November 8, 2010 at 2:00 p.m. revealed the soiled linen/utility on the 100 hall and 300 hall and the clean linen on the 300 hall were provided with doors that were severely damaged and must be replaced. Further observation on November 8, 2010 at 3:00 p.m. revealed the smoking room ceiling was constructed of unrated plywood. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation the facility failed to assure HVAC systems comply with NFPA 90A. The findings included:		E		K 029 NFPA 101 Life Safety StarsS=D What corrective action(s) will be accomplished for those residents have been affected by the deficient No residents were effected by this prenetrations were corrected. Ceiling repaired with 1/2 hour fire resistant of meet Life Safety Standard. Residents identified as having the to be affected by the same deficient. What corrective actions will be to affected by the same deficient. What corrective actions will be to affected by the same deficient. What corrective actions will be to all residents have a potential to be Education was given to maintenance 11-24-10 on the importance of ensuall corridors are equipped with 1/4 he rated materials. What measures will be put into president the deficient practice does not weekly rounds will be conducted by maintenance supervisor or designed all corridors are equipped with 1/4 he rated materials. How the corrective action(s) will monitored to ensure the deficient will not recur? Weekly rounds will be reviewed by executive director ensure compliant Safety Code. Weekly round finding taken to the PI meeting by the ED of the next 3 months which consists of D.O.N., ADON Rehabilitation, SDC Service, Executive Director, Activic Admissions, Medical Records, Director and the process of the consists of D.O.N., ADON Rehabilitation, SDC Service, Executive Director, Activic Admissions, Medical Records, Director, Activical	found to at practice? oractice. ag was naterials to e potential ant practice. aken? affected. ae staff on aring that our fire laced or to ensure our fire be practice y to ensure our fire be practice y the ce with Life g will be monthly for f. M.D., C, Social ties, HR, tary, and	12/25/10
	Observation and testing on November 8, 2010 at 3:30 p.m. revealed the supply and exhaust in the						

STATEMENT AND PLAN C	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445302		A. BUILDII	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 11/08/2010	
	ROVIDER OR SUPPLIER			REET ADDRESS, GITY, STATE, ZIP COD 1641 HIGHWAY 19E ELIZABETHTON, TN 37643		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 067		age 4 not run continuously.	K 067	K 067 NFPA 101 Life Safety SS=D What corrective action(s) will accomplished for those resider have been affected by the defice No residents were effected by the Exhaust fan now runs continuous Maintenance department made resource ensure exhaust fans run at all times to be affected by the same defice What corrective actions will be All residents have a potential to Education was given to maintens 11-24-10 on the importance of exhaust fans are on at all times. What measures will be put into systematic changes will be made that the deficient practice does Weekly rounds will be conducted maintenance supervisor or design exhaust fans are on at all times. How the corrective action(s) we monitored to ensure the deficient will not recur? Weekly rounds will be reviewed executive director ensure complication to the PI meeting by the El the next 3 months which consists D.O.N., ADON Rehabilitation, Service, Executive Director, Act Admissions, Medical Records, El Housekeeping Beginning Dec. 7	be its found to clent practice? is practice. sly. ounds to nes. the potential clent practice. taken? be affected. ance staff on insuring placed or de to ensure not recur? d by nee to consurc ill be ent practice by the ance with Life ling will be D monthly for s of: M.D., DC, Social ivities, HR, bictary, and	12/25/10